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ABSTRACT

The value of a role in a profession is often tied to demand for and supply of practitioners in this role. Since a profession may seek to sustain its role's value by influencing supply of recognized practitioners, the National Commission for Health Certifying Agencies has included in its membership criteria a requirement for administrative independence between credentialing agencies and their related professional associations. Some roles are born of a clearly defined need; others evolve through a more complex sequence of events. After identifying some common, distinguishing traits among themselves, a group names these traits and establishes a set of membership criteria that may eventually replace the traits as distinguishing characteristics. Some individuals with the orginial traits may be excluded and form a second group. The two groups may be rejoined, and through role delineation the two levels of practitioners with the same performance characteristics may merge. The profession of respiratory therapy has followed this evaluation pattern. Role delineation efforts recommended that Certified Respiratory Therapy Technicians and Registered Respiratory Therapists be combined into one entry-level generalist position. Impact of conclusions of a role delineation must, however, be considered, espocially regarding practicality of implementing a new or revised role in a profession. (YLB)

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Methodological Issues of Role Delineation for Professional Credentialing

The Pre-eminence of Political Realities Over Technical Considerations in the Role Delineation Process

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The Pre-eminence of Political Realities
Over Technical Considerations
in the Role Delineation Process

Being asked to speak about the relationship between politics and technical considerations reminds me of two comments made by Will Rogers. He said, "Now I read politics, talk politics, know personally almost every prominent politician, like 'em, and they are my friends, but I can't help it if I have seen enough of it to know that there is some baloney in it...I hope I never get so old that I can't peep behind the scenes and see the amount of politics that's mixed in this medicine before it's dished out to the people as "pure statesmanship." Those of you who would agree with this observation should reserve judgement of Mr. Rogers, because he also said, "I always felt there was only one thing that could possibly defeat Mr. Hoover's capable management of our affairs, and that was when he run out of practical men to put on commissions, and sure enough he is getting short-handed. Yesterdays commission didn't have a practical man on it. Every one was a college professor." This paper is about politics and practicality.

Political Realities

I shall begin by defining politics as the struggle between the "haves" and the "have-not's;" that is, between those who want It and those who want to keep It. The intensity of this struggle is determined by the value of It, and the value of It is in large measure dependent on Its relative rarity. Aluminum was once considered a precious metal used

to make jewelry, until someone discovered how to make lots of it cheaply. All the alchemists would have been out of business if one had successfully transmutted lead to gold. Would lead have become priceless or gold worthless? An entity is rare only so long as it is unavailable to someone who wants it. Not everything rare is valuable, but almost everything valuable is rare. Hence, an essential factor in our political reality is the struggle for possession of something which many want but only some can have.

In the evolution of a profession, It is a role or identity. The value or status of this role is often tied to the demand for and supply of practitioners in this role. A great demand coupled with a scarce supply results in a valuable role. Because demand for services may be beyond the control of a profession, a profession may seek to sustain the value of its role by influencing the supply of recognized practitioners. A profession may influence the supply of available practitioners through a variety of mechanisms, including inflated academic requirements, limited access to experiential learning, and restrictive credentialing.

It is this concern that prompted the National Commission for Health Certifying Agencies (NCHCA) to include in its membership criteria a requirement for administrative independence between credentialing agencies (the gateway to the professions) and their related professional associations (the arm representing the organized membership of a profession). It is interesting to note that of the forty some odd membership criteria, which includes requirements from fiscal accountability to validation procedures, this criterion generated the greatest amount of controversy.

The Evolution of a Role

There are some roles which are born of a clearly defined need. The widget maker is needed to operate the widget-making machine. The procedure for operating the widget-making machine can be clearly delineated. The widget maker is trained to perform only those functions necessary to produce a widget.

Other roles, however, evolve through a more complex sequence of events. A common pattern begins with a small group of individuals in geographic proximity to each other who identify some common traits among themselves which distinguish them as unique. These traits or attributes need not be important or even significant, but if they are to be valuable, they must be unique; that is, some have It and some do not. These traits are typically given a name (dooda therapy). The name rarely describes the traits fully but serves as a symbol by which all those who possess those traits may be recognized and distinguished from others.

To preserve the name, the group usually establishes a set of membership criteria. Only those meeting the criteria may be identified by that name. The criteria often have little to do with the traits which distinguish the group, because the traits themselves may be poorly defined. The criteria serve as substitutes for traits and may eventually replace the traits as the distinguishing characteristics of the group. Dues, academic degree, or membership in an affiliated group with different and unrelated membership criteria of its own are examples of this phenomena. If the process is carried to an extreme, some individuals who possess the original traits will be excluded from the group because they cannot or will not meet the substitute membership criteria.

In many professions this second group takes on a similar name (dooda technicians) and competes with the original group. Both groups may, in fact, do the same job and possess the same traits and skills but have a different set of substitute membership criteria.

Occasionally, the two groups will later rejoin but retain two sets of substitute membership criteria, establishing two levels of practitioners with the same performance characteristics.

Role Delineation

At this point in the evolutionary process, if a profession is lucky, some benevolent philanthropic organization (the Department of Health and Human Services) will offer unlimited funds to conduct a study to rectify the situation.

It is also at this point that political realities come into conflict with technical considerations.

No profession purposely and with malice of forethought creates for itself this paradoxical situation. Inadequate planning and forecasting combine with self-interest, professional insecurity, chauvinism, and a sense of misdirected competitiveness to propell a profession into this schizophrenic identity crisis.

The researcher who seeks to assist a profession with the delineation of its roles and functions cannot lose sight of the forces which contributed to the profession's current predicament. A role delineation is not a static document whose function is purely descriptive. It is a dynamic document which should function as a change agent.

When a role delineation identifies inconsistencies between a profession's current job description and its actual practice profile, the profession is faced with a number of significant problems. The "haves" must consider the possibility that the "have-not's" will be admitted to their exclusive club, or worse, that some of the loyal "haves" may become "have-not's."

If entry standards have been inflated, role delineation may be viewed as a step backward or downward by the profession. Professional status may be threatened, earning power may be compromised, and fewer new "high quality" personnel may be attracted to the field.

These fears are real and can result in resistance to data collection, interference with the dissemination of results, and rejection of conclusions. Recommendations may be disregarded or ignored and a technically valid study may end up collecting dust on the researchers' shelves.

Respiratory Therapy: A Case Study

Respiratory therapy is a relatively new health profession which, during its evolution over the last 30 years, has followed many of the patterns described above.

Beginning in 1971 and continuing through 1978, the Division of Associated Health Professions, Health Resources Administration, funded several contracts with organizations representing the profession of respiratory therapy. The Division was empowered under Public Law 91-519, Title II, Section 792(c)(2) to "enter into contracts...for special projects relating to training or

retraining of allied health personnel, including...(f) developing, demonstrating, or evaluating techniques for appropriate recognition (including equivalency and proficiency testing mechanisms) of previously acquired training or experience." PL 92-603, Section 1123, authorized the Secretary to carry out a program designed to determine the proficiency of individuals (who do not otherwise meet the formal educational, professional, membership, or other specific criteria established for determining the qualifications of particular health groups) to perform the duties and functions of those health groups. If any individual was determined qualified, no person or provider using the services of such individual to perform such duties and functions would be denied payment under Title XVIII on the grounds that such an individual was not qualified.[3]

Had the organized leadership of this profession clearly understood this mandate, subsequent events indicate they may not have pursued these emperical studies. Clearly the government's interest was to open avenues for entry to the health professions which the professions themselves had closed.

Early Role Delineation Efforts

During the period from June, 1972 to June, 1974, the then Division of Allied Health Professions, Bureau of Health Manpower Education, National Institutes of Health, contracted with the American Association for Respiratory Therapy and The Psychological Corporation to develop criterion-referenced proficiency examinations for respiratory therapy personnel. In this two-phase project, the Association was responsible for producing a delineation of roles and functions for at least two competency levels to

serve as a criterion base for these examinations. The final report from phase one identified four such levels (I through IV) and recommended that Levels II and III be used for examination development.[4] In the second phase, The Psychological Corporation developed two sets of examinations to test the skills described for Levels II and III in the role delineation document.[5]

In 1975 a correlation study of these examinations was conducted during which the Educational Testing Service administered the Level III Proficiency Examination with the 2288-candidate Written Registry Examination of the National Board for Respiratory Therapy (NBRT); the Level II Proficiency Examination was administered with the NBRT Written Certification Examination to 3921 certification candidates.[6] The results of this study, along with other activities intended to upgrade the profession's understanding of criterion-referenced measurement (CRM), revealed two important problems.

1) The roles and functions were arranged according to therapeutic modalities, e.g., IPPB, Aerosol Therapy, Gas Therapy, etc. These were distinctly not competencies and as such did not lend themselves to creating a hierarchy of skills which apply to more than one therapeutic circumstance. Without such a hierarchy, it was difficult to identify the more important competencies under which component skills could be clearly linked.

2) Very broad competencies were not described specifically enough to communicate with precision what would be expected of the practi-

tioner for effective performance. For example, the skill "Assess patient response" appeared eleven times in the Levels II and III role descriptions with no indication as to the particular assessments for which the practitioner would be responsible.

Need for a New Role Delineation

Despite some of the relatively disappointing aspects of the 1973-75 delineation and proficiency examination projects, a very positive result was realized. Through continuing involvement in this work and in combination with advances in practical applications of CRM theory, the profession's understanding of CRM was considerably refined. The realization that CRM might hold a key to developing national competency assurance programs in the future created a strong commitment to pursue unlocking this potential.

This commitment, shared by the Division of Associated Health Professions, resulted in an invitation by the Division for the profession to submit a proposal for accomplishing a broad range of activities, among them a revised role delineation. This second attempt to delineate the roles and functions of respiratory therapy personnel was conducted from July, 1975 to April, 1978. The primary objective of the project was to assemble a clear and specific description of the minimum basic competencies required for effective clinical performance. Furthermore, it was intended that this description constitute an appropriate base for developing certifying examinations to assess the competence of individuals at entry to respiratory therapy practice.

The project methodology called for the development of a hypothetical role based on the experience of a panel of experts, followed by a profile

of practice survey to verify the initial delineation. A total of 4618 survey instruments were returned from 530 hospitals, representing a response of 81.2 percent.

Based on results of the research, the final report concluded that "for the express purpose of certifying practitioners in such a way as to match current job expectations, no substantial and consistent distinction could be described when comparing the practice characteristics of Certified Respiratory Therapy Technicians and Registered Respiratory Therapists. Therefore, it has been recommended that a single entry-level generalist position be considered for certifying respiratory therapy practitioners and that the role delineation...be accepted as the description for that position."[7]

Needless to say, this conclusion presented organized respiratory therapy with some serious problems to resolve. By 1978 there were over 200 schools preparing individuals to practice as respiratory therapy technicians and a like number of schools preparing individuals to be respiratory therapists. The duration and subject matter of these two categories of academic institutions differed significantly. Furthermore, the credentialing process and financial remuneration for the graduates of these schools reflected this difference in academic preparation. If the leadership in respiratory therapy accepted the conclusions of this report, they would be obliged to reorganize the formal training system, revise the national certifying examinations, and adjust the pay scales in thousands of hospitals employing respiratory therapy practitioners. The resulting

confusion would undoubtedly damage the status of the profession and create considerable confusion among hospital administrators, physicians, and other health care providers.

The issue was hotly debated in 1979 at a variety of professional forums and was finally resolved when the board of trustees of the National Board for Respiratory Therapy, the professional certifying agency for the discipline, voted to develop a single entry-level examination for all graduates of accredited respiratory therapy programs, regardless of category. This action was precipitated by a number of events, including a call from experienced technicians demanding an alternate route to eligibility (other than the formal academic route) to the upper level examination, a declining pass rate (approximately 25 percent) on this upper level registry examination, an expanding population of lower level technicians (three times the number of therapists), and perhaps most important, a class action suit brought against the practices and activities of the NBRT, The American Association for Respiratory Therapy (AART), and several hospitals in the Chicago area. It was alleged that the defendants had conspired to control the personnel market by promoting and hiring only credentialed practitioners, a violation of antitrust laws. Although the plaintiffs were unable to substantiate this claim to the satisfaction of the court, the NBRT became convinced that it was in the best interests of the profession to prove beyond a shadow of a doubt the validity of its credentialing system. To this end, the NBRT conducted a number of validation studies which demonstrated both the content validity and predictive validity of its examinations. In addition, the NBRT adopted a policy which incorporated five significant points. All future examination development would include:

1) a personnel census, 2) a position classification viability study, 3) a role delineation, 4) a profile of practice survey to verify the role, and 5) a predictive or concurrent validity study. This policy is, to the best of my knowledge, the most stringent test development policy adopted by any health certifying agency in the United States.

Caveat

As of the writing of this paper, several relevant issues remain unresolved.

The Joint Review Committee for Respiratory Therapy Education (JRCRTE), the school accreditation agency for the profession, continues to accredite two separate levels of academic institutions. The AART, the professional association, has recently passed a resolution calling for the minimum academic preparation for individuals entering the profession to be raised from a one-year certificate program to an associate of science degree. It is interesting that this resolution was passed without any emperical evidence to justify its implementation.

Conclusions and Recommendations

Any effort to delineate the roles and functions of an occupation must be sensitive to the impact of its conclusions on the personnel who currently practice. Many factors contribute to the practicality of implementing a new or revised role in a profession. Considerations having little to do with the technical validity of research may take precedence . Significant factors include the cost of modifying a training system, interruptions

in the flow of new personnel entering the field and subsequent workforce shortages, confusion among employers regarding hiring and reassignment of personnel, devaluation of credentials resulting in an increased attrition among practicing professionals, a loss of confidence by the client or patient in the credibility of the professional, and finally, the time and energy to effect revolutionary change in a beast accustomed to slow evolutionary change.

Margaret Wilson, a project officer for many of the role delineation efforts conducted by the Division of Associated Health Professions during the last decade, has suggested ten questions regarding the viability of a position which must be considered. These questions should be seriously considered before role delineation efforts are undertaken in the future. A negative answer to any of the questions can impede or negate the benefits derived from role delineation. Unless some mechanism is derived to address these items, technical precision may simply be an exercise in frustration.

1) Will the role contribute to quality client care?
2) Will the role contribute to sound employment practices?
3) Will the role provide a base for sound educational programs?
4) Will the role provide a base for sound credentialing practice?
5) Will the role provide a base for sound educational program evaluation?
6) Will the role contribute to career mobility?
7) Is the role congruent with common staffing patterns?
8) Will the role contribute to the congruency of the field?
9) Will the role contribute to the promotion of the field?
10) Is the role acceptable to: a) clients, b) practitioners, c) employers, d) educators, and e) third party payers

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